



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

*Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary*

December 14, 2015

The Honorable Peter A. Hammen  
Chair, Health & Government Operations Committee  
House Office Building, Room 241  
6 Bladen Street  
Annapolis, MD 21401-1991

Re: Workgroup on HB 1101 (2015) – Department of Health and Mental Hygiene –  
Health Program Integrity and Recovery Activities

Dear Chair Hammen: *Re*

Pursuant to your letter to me dated April 13, 2015, the Department of Health and Mental Hygiene (the Department) convened a workgroup of provider representatives and other interested stakeholders to collaborate with the Department on drafting a bill for the 2016 session that would strengthen the Department's ability to audit and recover overpayments from providers that receive Departmental funding. Specifically, you requested that, at minimum, the legislation ideally should:

1. Provide the Department with the same tools used by the U.S. Department of Health and Human Services Office of the Inspector General to determine and recover the amount of any overpayment by the Department to a provider as reimbursement for a health care service or health care item provided to a participant; and
2. Afford the providers full documentation of the basis for any finding of an overpayment and an opportunity to contest any finding of an overpayment through the Administrative Procedure Act.

This report is submitted as requested by your April correspondence, describing the workgroup's deliberations and findings and includes the workgroup's recommendation for 2016 legislation. I am pleased to advise you that the Department and the healthcare industry stakeholders were able to develop compromise language to address the requirements cited above.

If you have any questions regarding this report, please contact Allison Taylor, Director of the Office of Governmental Affairs, at 410-767-6481 or at [allison.taylor@maryland.gov](mailto:allison.taylor@maryland.gov).

Sincerely,

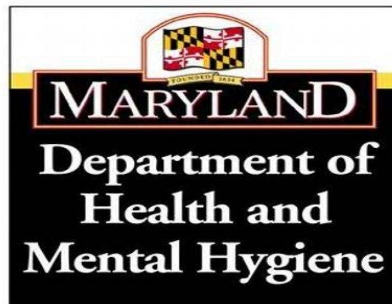
Van T. Mitchell  
Secretary

Enclosures

cc: Health and Government Operations Committee Members  
Susan R. Steinberg, Esq.  
Shannon McMahon  
Allison Taylor, J.D., M.P.P.







**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

**OFFICE OF THE INSPECTOR GENERAL**

**Health Program Integrity and Recovery Activities**

**HB 1101 (2015) Workgroup to Draft Legislation**

Larry Hogan, Governor  
Boyd Rutherford, Lt. Governor  
Van T. Mitchell, Secretary

December 2015



## **Introduction:**

This report is submitted by the Office of the Inspector General within the Department of Health and Mental Hygiene (Department) pursuant to correspondence dated April 13, 2015, from Chairman Hammen to Secretary Mitchell, which requested the Department to convene a workgroup of provider representatives and other interested stakeholders to advise the Department on drafting a bill for the 2016 session. The purpose of the bill would be to strengthen the Department's ability to audit Medical Assistance (Medicaid) and other providers who receive funding from the Department and recover overpayments to these providers for false, fraudulent, or improper claims. At minimum, Chair Hammen's letter requested that the legislation ideally should:

1. Provide the Department with the same tools used by the U.S. Department of Health and Human Services Office of the Inspector General to determine and recover the amount of any overpayment by the Department to a provider as reimbursement for a health care service or health care item provided to a participant; and
2. Afford the providers full documentation of the basis for any finding of an overpayment and an opportunity to contest any finding of an overpayment through the Administrative Procedure Act.

During the 2015 legislative session, HB 1101 was introduced by the Chair of the Health and Government Operations (HGO) Committee at the request of the Department. The bill sought authority for several program integrity initiatives for the Department including the following:

1. Provide the Inspector General for the Department, or a designee of the Inspector General, with the authority to issue a subpoena for the purposes of investigating fraud, waste, or abuse of Departmental funds;
2. Provide the Department, the Inspector General, or a contractor or agent acting on behalf of the Department, with authority to use extrapolation to determine the rate of error or overpayment and set forth limitations on the use of extrapolation;
3. Provide the Department with the authority to impose a civil money penalty against a provider in lieu of recoupment of an entire claim when a provider fails to meet statutory or regulatory requirements; and
4. Provide the Department with the authority to require a surety bond or other security from certain Medicaid providers to cover financial liability should the provider owe the State funds for fraud, waste, or abuse of funds.

Opposition from the health care community was strong. Efforts to develop a compromise bill failed during the session. However, the HGO Committee recognized the need for the Department to have certain tools to assist with its program integrity efforts. The Chair of the HGO Committee therefore requested that the Department work with stakeholders to determine if a compromise bill could be drafted.

## **Additional Background Information:**

The Department is subject to audits by the federal government, including the U.S. Department of Health & Human Services, Office of the Inspector General (HHS-OIG). The HHS-OIG conducts reviews/audits of Medicaid providers, either a single provider or a group of providers, to ensure the provider is providing the services and submitting claims for the service in accordance with State and federal regulations. The audit findings will be issued to the State Medicaid Program, and not to the provider. The federal government provides partial funding (called Federal Financial Participation (FFP)) to the State, which in turn uses the funds to pay for services. As the “contractual” relationship for the funding is between the federal and State government, and not the federal government and the provider, the federal government will request recovery of any overpayment from the State. The State may or may not be able to then recover the funds from the provider.

The HHS-OIG and other federal agencies and their agents use extrapolation to determine the error rate and amount of recovery. The HHS-OIG uses a statistical software package, RAT-STAT, to select random samples and estimate improper payments. RAT-STAT is within the public domain and the Centers for Medicare and Medicaid Services (CMS) encourages the use of the tool by states and Medicaid and Medicare providers.

## **Workgroup:**

The workgroup convened five meetings: June 10<sup>th</sup>, July 16<sup>th</sup>, August 20<sup>th</sup>, October 15<sup>th</sup>, and November 18<sup>th</sup>. The meetings were held at the Department’s headquarters at 201 West Preston Street, Baltimore, MD 21201. In addition, individuals could participate in the meetings by calling a toll-free telephone number. The meetings were publicized via email to all parties that submitted an email address to the workgroup’s staff and were publicized on the Maryland General Assembly’s website. Susan Steinberg, Acting Inspector General and Shannon McMahan, Deputy Secretary, Health Care Financing co-chaired the meetings.

Spending for health care services and products has increased significantly over the past few years, especially with the increased Medicaid enrollment as a result of the federal Affordable Care Act. The State pays billions of dollars to Medicaid providers and other providers that participate in programs funded by the Department. The workgroup reconsidered four main areas for providing the Department with additional ability to audit providers and seek recovery for false, fraudulent, or improper claims: (1) subpoena power; (2) civil money remedy; (3) extrapolation; and (4) surety bonds.

## **Subpoena Authority:**

HB 1101 provided the Inspector General or a *designee of the Inspector General* authority to issue subpoenas. At the legislative hearings, opposition to “a designee of the Inspector General” having this authority was raised. At the first workgroup meeting, the Department proposed that in lieu of “designee of the Inspector General,” that the language read “the Inspector General or a designated Assistant Inspector General....” The proposal was accepted by the workgroup without dissent.

## **Civil Money Damages:**

HB 1101 provided language that would permit the Department to impose civil money damages in lieu of full recovery of a claim in certain situations when the provider failed to meet statutory or regulatory requirements yet did in fact provide a service. At the hearings in Annapolis, there was much confusion over this provision, many seeing it as a penalty on the providers when actually the provision was meant to assist the providers. In lieu of full recovery of a claim, the State was seeking to provide an alternative to full recovery and accept a lesser amount to settle the issue.

A workgroup session was spent explaining civil money damages. A representative of the Office of the Attorney General, Medicaid Fraud Control Unit, explained how the Civil False Claims Acts works and how that Act would be different from imposing civil money damages, which is an administrative recovery. After much discussion, a representative of the provider community suggested referring to the remedy as a civil money “remedy” rather than civil money “damages” as a way to clarify it was not a “penalty.” Everyone supported the suggestion and drafted acceptable language to permit civil money remedies.

During the weeks of the workgroup, the Office of the Attorney General and the Medicaid Program became concerned as to whether CMS would accept less than a full refund of its share of Medicaid funding if the State, by opting to apply a civil money remedy, reduced the amount of the overpayment it recovered. Thus, the proposed language of the bill states that the recovery cannot be less than the FFP, the amount that the State receives from the federal government for the claim. In addition, the use of the remedy would be within the sole discretion of the Department. The workgroup agreed to the proposed language.

## **Extrapolation:**

HB 1101 provided that the Department, the Inspector General, or any contractor or agent acting on behalf of the Department, could extrapolate the error rate or overpayment if required by federal statute, if there was a high payment error, or if educational intervention by the Department or its agent had failed to correct the payment error. The proposed language was opposed by the health care industry and several legislators. At the hearings before the subcommittee, compromise language was proposed to limit the use of extrapolation to audits after the federal government had conducted a review and demanded recovery of overpayments from the Department. Compromise language was not able to be negotiated during the session.

The Department sought legislation permitting extrapolation for several reasons. Determining the overpayment through sampling and extrapolation, rather than reviewing each claim, is both economical and in the best interest of the provider and the State. Otherwise, the Department would need to audit every claim of a provider within the review period. If the provider contested any identified recovery, the Department would need to prove each claim at a hearing. The process would be very time consuming and expensive.

In addition, the federal government-HHS-OIG currently conducts audits of Maryland Medicaid providers. The federal government uses extrapolation in computing the error rate and the amount of recovery due from the State. The identified recovery is from the Department and not the individual providers, as it is the Department that has the contractual or statutory relationship with the federal government. The Department would need to conduct its own review in order to recover the funds from the individual providers. Presently, when the HHS-OIG uses extrapolation in its recovery of the overpayment of funds to the Department, the Department is not able to use extrapolation in order to recoup funds from the provider, and thus potentially millions of dollars are not recouped.

Workgroup discussions: At the request of the workgroup, the Department arranged for Mr. Bernard Siegel, HHS-OIG, to participate by telephone at the July 16th meeting. Mr. Siegel spoke and answered questions for an hour and participants were asked to submit additional questions in writing. No additional questions were received. Mr. Siegel explained how HHS-OIG conducts its reviews. There was a discussion of RAT-STAT and error rates. Health care industry representatives opposed inclusion of clerical errors in the error rate, which forms the basis for an extrapolation. Mr. Siegel explained that HHS-OIG includes all errors in the error rate, including clerical errors.

The representatives for the health care industry were adamant in their opposition against broad authority for extrapolation. Compromise language was proposed limiting extrapolation to certain circumstances should the federal government or its agent conduct an audit using extrapolation. A subset of the representatives from the health care industry submitted proposed language. After numerous discussions with the representatives of the industry, the Department agreed to almost all the recommendations. Language was included to require a statistician to be involved in the sampling process, and more specific details for the appeal process were included. The only issue of contention that remained was whether clerical errors should be included in the error rate. The Department maintains that if it is following the methodology used by the federal government, then the clerical errors must remain in the error rate.

### **Surety Bonds:**

HB 1101 was drafted to give the Department the authority to require surety bonds from Medicaid providers and Medicaid provider applicants. The bill did not list the types of providers who would be required to be bonded; however, it stated that the amount of the bond must be equal to the amount required by Medicare, if Medicare required a surety for that particular provider type. If Medicare did not require a surety bond, the amount would be based upon provider type, number of provider locations, average annual Medicaid revenue of the provider, and could not exceed \$50,000 per provider. The provider community was united in its opposition to this aspect of the legislation.

At the workgroup meetings, the provider community continued to voice opposition to surety bonds and did not suggest alternative language. The Department proposed that the State would only require a bond or security if the federal government also required a bond or security from the provider type in order to be a Medicare provider. The terms of the bond would be



identical to the federal requirements. The health care industry representatives opposed this proposal stating that Medicaid providers make too little money serving Medicaid clients and thus cannot afford the surety and would not be willing to continue as Medicaid providers. The Department has agreed not to include surety bonds in the program integrity bill.

**Conclusion:**

A final workgroup meeting was held on November 18, 2015. The Department's final proposal was submitted to the workgroup in advance of the meeting. In addition, a comparison chart summarizing the original HB 1101 legislation and comparing it to the industry's proposal and the Department's final proposal was presented. All attendees agreed to the proposed language. Although the industry representatives all voiced they would have preferred no bill, they agreed to recommend that their clients accept the Department's final proposal as drafted. (See Attachment A (Department's final proposed bill) and Attachment B (Comparison Chart)).

It is the position of the Department and the workgroup that the proposed legislation meets the directive contained in Chair Hammen's letter (See Attachment C (Chair Hammen's letter)). Compromise legislation has been drafted that provides the Department with the same tools used by the HHS-OIG to determine and recover the amount of any overpayment by the Department to a provider as reimbursement for a health care service or health care item provided to a participant, and affords providers full documentation of the basis for any finding of an overpayment and an opportunity to contest any finding of an overpayment through the Administrative Procedure Act. The Department greatly appreciates the cooperation afforded by the health care industry representatives and the members of the legislature that participated in the workgroup.



## **Attachment A**

### **HB 1101 (2015) Workgroup**

A BILL ENTITLED

AN ACT concerning

#### **Department of Health and Mental Hygiene – Health Program Integrity and Recovery Activities**

FOR the purpose of authorizing the Inspector General or an Assistant Inspector General in the Department of Health and Mental Hygiene to subpoena certain persons or evidence, administer oaths, and take depositions and other testimony for the purpose of investigating fraud, waste, or abuse of departmental health program funds; authorizing a certain court to take certain actions if a person fails to comply with a certain order or subpoena; authorizing the Inspector General to impose a civil money remedy against a provider for a certain violation under certain circumstances; establishing the maximum amount of a civil money remedy; specifying the factors that must be considered in setting the amount of a civil money remedy; requiring the Inspector General to provide certain notice to a provider of the imposition of a civil money remedy; requiring the notice to be served in a certain manner and to include certain information; establishing a certain right to appeal from an order imposing a civil money remedy; requiring a provider to pay a civil money remedy within a certain period; authorizing the Inspector General to use extrapolation to determine the rate of error or overpayment under certain circumstances; providing that an audit of a provider may be conducted using extrapolation to determine the rate of error or overpayment for certain claims made by the provider; specifying the types of claims that may not be included in a sample to be used for extrapolation; specifying the qualifications of certain individuals conducting an audit for the Inspector General; requiring the Inspector General to provide certain notice within a certain timeframe to a health care provider; requiring the Inspector General to conduct an exit conference and provide certain information to a health care provider; authorizing a health care provider to challenge certain

findings and conclusions during the exit conference; requiring the Inspector General to issue a final report and recovery letter; authorizing a health care provider to appeal a final determination by the Inspector General; defining certain terms; and generally relating to the Department of Health and Mental Hygiene and health program integrity and recovery activities.

BY repealing and reenacting, with amendments,

Article – Health – General  
Section 2-503  
Annotated Code of Maryland  
(2015 Replacement Volume)

BY adding to

Article – Health – General  
Section 2-504.1  
Annotated Code of Maryland  
(2015 Replacement Volume)

BY adding to

Article – Health – General  
Section 2-701 through 2-705 to be under a new subtitle “Subtitle 7.  
Use of Extrapolation in Recovery of Health Claim Overpayments”  
Annotated Code of Maryland  
(2015 Replacement Volume)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

**Article – Health – General**

2-503.

(a) The Inspector General:

(1) May investigate fraud, waste, and abuse of departmental funds;

(2) Shall cooperate with and coordinate investigative efforts with the Medicaid Fraud Control Unit and where a preliminary investigation

establishes a sufficient basis to warrant referral, shall refer such matters to the Medicaid Fraud Control Unit; and

(3) Shall cooperate with and coordinate investigative efforts with departmental programs and other State and federal agencies to ensure a provider is not subject to duplicative audits.

**(B) (1) THE INSPECTOR GENERAL OR A DESIGNATED ASSISTANT INSPECTOR GENERAL MAY SUBPOENA ANY PERSON OR EVIDENCE, ADMINISTER OATHS, AND TAKE DEPOSITIONS AND OTHER TESTIMONY FOR THE PURPOSE OF INVESTIGATING FRAUD, WASTE, OR ABUSE OF DEPARTMENTAL FUNDS.**

**(2) IF A PERSON FAILS TO COMPLY WITH A LAWFUL ORDER OR SUBPOENA ISSUED UNDER THIS SUBSECTION, ON PETITION OF THE INSPECTOR GENERAL OR A DESIGNATED ASSISTANT INSPECTOR GENERAL, A COURT OF COMPETENT JURISDICTION MAY COMPEL:**

**(I) COMPLIANCE WITH THE ORDER OR SUBPOENA; OR**

**(II) TESTIMONY OR THE PRODUCTION OF EVIDENCE.**

**2-504.1.**

**(A) WITHIN THE SOLE DISCRETION OF THE INSPECTOR GENERAL, AND EXCEPT AS OTHERWISE PROHIBITED BY STATE OR FEDERAL LAW, THE INSPECTOR GENERAL MAY IMPOSE A CIVIL MONEY REMEDY AGAINST A PROVIDER FOR VIOLATION OF STATE OR FEDERAL LAW GOVERNING CONDITIONS OF PAYMENT FOR ANY SERVICE OR ITEM FOR WHICH THE PROVIDER SUBMITTED A CLAIM FOR PAYMENT AND RECEIVED PAYMENT.**

**(B) A CIVIL MONEY REMEDY IMPOSED UNDER THIS SECTION:**

**(1) IS IN LIEU OF FULL PAYMENT OR FULL ADJUSTMENT OF THE PAID CLAIM AND NOT IN ADDITION TO REPAYMENT OF THE CLAIM;**

**(2) MAY NOT BE LESS THAN THE FEDERAL FINANCIAL PARTICIPATION SHARE OF THE IDENTIFIED IMPROPER CLAIM AMOUNT;**

**(3) MAY NOT BE IMPOSED IF THE CLAIM WAS INCLUDED IN THE UNIVERSE OF CLAIMS UNDER AN EXTRAPOLATION CALCULATION; AND**

**(4) IS ONLY AVAILABLE IF THE PROVIDER HAS NOT BEEN SUBJECTED TO A REPAYMENT PENALTY OR FINE, A CRIMINAL ACTION, OR A CIVIL FALSE CLAIMS ACTION UNDER EITHER FEDERAL OR STATE LAW, FOR THE SAME CLAIM.**

**(C) (1) A CIVIL MONEY REMEDY MAY NOT EXCEED THE AMOUNT OF REIMBURSEMENT THAT THE PROVIDER RECEIVED FOR THE PAID CLAIM.**

**(2) IN DETERMINING WHETHER TO IMPOSE A CIVIL MONEY REMEDY UNDER THIS SECTION AND IN SETTING THE AMOUNT OF THE CIVIL MONEY REMEDY, THE INSPECTOR GENERAL SHALL CONSIDER:**

**(I) THE NUMBER, NATURE, AND SERIOUSNESS OF THE VIOLATIONS;**

**(II) THE PROVIDER'S HISTORY OF COMPLIANCE;**

**(III) THE EFFORTS MADE BY THE PROVIDER TO CORRECT THE VIOLATIONS AND ANY CONTINUATION OF CONDUCT AFTER NOTIFICATION OF POSSIBLE VIOLATIONS;**

**(IV) THE PROVIDER'S LEVEL OF COOPERATION WITH THE DEPARTMENT OR INSPECTOR GENERAL AS IT RELATES TO THE REVIEW OF THE CLAIM;**

**(V) THE DEGREE OF RISK TO THE HEALTH, LIFE, OR SAFETY OF CONSUMERS AS A RESULT OF THE VIOLATIONS; AND**

**(VI) ANY OTHER REASONABLE FACTORS AS FAIRNESS MAY REQUIRE.**

**(3) IN WEIGHING THE FACTORS SET FORTH IN PARAGRAPH (2) OF THIS SUBSECTION, THE INSPECTOR GENERAL SHALL, WHERE APPROPRIATE, GIVE SPECIAL CONSIDERATION TO:**

**(I) THE EXTENT TO WHICH THE PROVIDER'S SIZE, OPERATIONS, OR FINANCIAL CONDITION MAY HAVE CONTRIBUTED TO THE VIOLATIONS; AND**

**(II) THE EXTENT TO WHICH THE PROVIDER'S SIZE, OPERATIONS, OR FINANCIAL CONDITION MAY AFFECT THE PROVIDER'S**

**ABILITY TO PROVIDE CARE AND CONTINUE OPERATIONS AFTER PAYMENT OF A CIVIL MONEY REMEDY.**

**(D) IF A CIVIL MONEY REMEDY IS IMPOSED UNDER THIS SECTION, THE INSPECTOR GENERAL SHALL ISSUE A WRITTEN NOTICE AND ORDER TO THE PROVIDER STATING THE TOTAL AMOUNT OF THE CIVIL MONEY REMEDY AND THE FOLLOWING INFORMATION;**

- (1) THE BASIS ON WHICH THE ORDER IS MADE;**
- (2) EACH REGULATION OR STATUTE VIOLATED;**
- (3) THE AMOUNT OF EACH CIVIL MONEY REMEDY FOR EACH VIOLATION;**
- (4) THE NUMBER OF CLAIMS AND TOTAL VALUE OF THE CLAIMS WITH THE IDENTIFIED ERRORS; AND**
- (5) THE MANNER IN WHICH THE AMOUNT OF THE CIVIL MONEY REMEDY IS CALCULATED.**

**(E) THE NOTICE AND ORDER SHALL BE SERVED ON THE PROVIDER BY CERTIFIED MAIL AND SHALL INCLUDE A STATEMENT ON THE PROVIDER'S RIGHT TO APPEAL THE ORDER IN ACCORDANCE WITH TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE.**

**(F) (1) AN ORDER IMPOSING A CIVIL MONEY REMEDY IS FINAL WHEN THE PROVIDER HAS EXHAUSTED ALL OPPORTUNITIES TO CONTEST THE CIVIL MONEY REMEDY IN ACCORDANCE WITH THE ADMINISTRATIVE PROCEDURE ACT IN CONTESTED CASES UNDER TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE .**

**(2) UPON EXHAUSTION OF ALL APPEALS, A PROVIDER SHALL PAY A CIVIL MONEY REMEDY TO THE DEPARTMENT WITHIN 10 DAYS AFTER THE PROVIDER RECEIVES A FINAL ORDER AFFIRMING THE IMPOSITION OF A CIVIL MONEY REMEDY UNLESS THE DEPARTMENT OR INSPECTOR GENERAL NEGOTIATES AND APPROVES A REPAYMENT SCHEDULE.**

**(G) (1) THE INSPECTOR GENERAL, IN CONSULTATION WITH STAKEHOLDERS, SHALL DEVELOP REGULATIONS TO IMPLEMENT THIS SECTION.**

**SUBTITLE 7. USE OF EXTRAPOLATION IN RECOVERY OF  
HEALTH CLAIM OVERPAYMENTS.**

**2-701.**

**(A) IN THIS SUBTITLE, THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.**

**(B) (1) “CLAIM” HAS THE MEANING STATED IN § 2-501 OF THIS TITLE.**

**(2) “EXTRAPOLATION” MEANS THE PROCESS OF ESTIMATING AN UNKNOWN VALUE BY PROJECTING WITH A CALCULATED PRECISION OR MARGIN OF ERROR THE RESULTS OF THE REVIEW OF A SAMPLE TO THE UNIVERSE FROM WHICH THE SAMPLE WAS DRAWN USING A STATISTICALLY VALID SAMPLING METHODOLOGY.**

**(3) “FEDERAL GOVERNMENT” MEANS AN AGENCY OF THE UNITED STATES GOVERNMENT OR A CONTRACTOR RETAINED BY THE AGENCY OF THE UNITED STATES GOVERNMENT.**

**(4) “OVERPAYMENT” MEANS A PAYMENT MADE BY THE DEPARTMENT TO A HEALTH CARE PROVIDER FOR SERVICES OR GOODS FOR WHICH A CLAIM WAS SUBMITTED TO THE DEPARTMENT, WHICH IS FOUND TO BE INCORRECT AND RESULTS IN A PAYMENT GREATER THAN THAT TO WHICH THE PROVIDER IS ENTITLED.**

**(5) “PROGRAM” HAS THE MEANING STATED IN § 2-501 OF THIS TITLE.**

**(6) “PROVIDER” HAS THE MEANING STATED IN § 2-501 OF THIS TITLE.**

**(7) “STATISTICALLY VALID SAMPLING METHODOLOGY” MEANS A METHODOLOGY USED FOR EXTRAPOLATION THAT HAS A CONFIDENCE LEVEL OF NINETY PERCENT OR GREATER AND IS VALIDATED BY A STATISTICIAN WHO POSSESSES A MASTER’S DEGREE IN STATISTICS.**



**(8) “UNIVERSE” MEANS A DEFINED POPULATION OF CLAIMS SUBMITTED BY A HEALTH CARE PROVIDER AND PAID TO THE HEALTH CARE PROVIDER BY THE DEPARTMENT DURING A SPECIFIED TIME PERIOD.**

**2-702.**

**(A) SUBJECT TO THE REQUIREMENTS OF THIS SUBTITLE, THE OFFICE OF THE INSPECTOR GENERAL, OR A CONTRACTOR OR AN AGENT ACTING ON BEHALF OF THE INSPECTOR GENERAL, MAY USE EXTRAPOLATION DURING AN AUDIT TO RECOVER AN OVERPAYMENT FROM A HEALTH CARE PROVIDER IF:**

**(1) THE FEDERAL GOVERNMENT HAS ALSO CONDUCTED AN AUDIT OF THE PROGRAM FOR OVERPAYMENT; AND**

**(2) THE MONETARY RECOVERY AMOUNT DETERMINED TO BE DUE BY THE PROGRAM TO THE FEDERAL GOVERNMENT IS BASED ON THE FEDERAL GOVERNMENT’S USE OF EXTRAPOLATION.**

**(B) THE AUDIT CONDUCTED BY THE DEPARTMENT UNDER SUBSECTION (A) OF THIS SECTION SHALL BE LIMITED TO THE SCOPE OF THE FEDERAL AUDIT, INCLUDING CLAIMS FOR THE SAME AUDIT TIME PERIOD AND SAME TYPE OF CLAIMS.**

**2-703.**

**(A) UPON A FINDING OF OVERPAYMENT TO A HEALTH CARE PROVIDER, THE DEPARTMENT MAY NOT USE EXTRAPOLATION UNLESS THERE IS A DETERMINATION OF A SUSTAINED OR HIGH LEVEL OF PAYMENT ERROR, AS DEFINED BY REGULATIONS;**

**(B) WHEN USING EXTRAPOLATION TO DETERMINE AN OVERPAYMENT, THE SAMPLE TO BE USED MAY NOT INCLUDE CLAIMS:**

**(1) IN WHICH THE ALLEGED OVERPAYMENT WOULD HAVE NO FISCAL IMPACT ON THE ENTIRE SAMPLE;**

**(2) THAT WERE SUBMITTED IN ACCORDANCE WITH THE DEPARTMENT OR INSPECTOR GENERAL OR PROGRAM’S DIRECTIVES, POLICIES, GUIDELINES, OR REGULATIONS; OR**

**(3) THAT ARE THE RESULT OF AN UNINTENTIONAL OVERLAP IN SERVICES AMONG UNRELATED HEALTH CARE PROVIDERS CAUSED BY CIRCUMSTANCES BEYOND THE CONTROL OF THE PROVIDER THAT IS SUBJECT TO THE AUDIT, IN WHICH CASE THE DEPARTMENT MAY RECOVER THE ORIGINAL OVERPAYMENT.**

**2-704.**

**(A) AN EMPLOYEE OR CONTRACTOR OF THE DEPARTMENT CONDUCTING AN AUDIT UNDER THIS SUBTITLE IN WHICH EXTRAPOLATION MAY BE USED SHALL:**

**(1) PERFORM THE AUDIT IN ACCORDANCE WITH A METHODOLOGY USED BY THE FEDERAL GOVERNMENT OR CONDUCTED IN ACCORDANCE WITH GENERALLY ACCEPTED AUDITING STANDARDS (GAAS) AND STATEMENT ON ACCOUNTING STANDARDS (SAS);**

**(2) USE A STATISTICALLY VALID SAMPLING METHODOLOGY;  
AND**

**(3) MEET THE FOLLOWING QUALIFICATIONS:**

**(I) HAVE AT LEAST THREE YEARS AUDITING  
EXPERIENCE;**

**(II) HAVE EXPERIENCE IN THE PROCEDURAL CODING  
PROGRAM USED FOR THE CLAIM;**

**(III) BE FAMILIAR, EITHER INDEPENDENTLY OR THROUGH  
TRAINING BY THE HEALTH CARE PROVIDER, WITH THE FORMAT AND  
CONTENT OF PAPER AND ELECTRONIC MEDICAL RECORDS AND CLAIM FORMS  
USED BY THE HEALTH CARE PROVIDER; AND**

**(IV) HAVE GENERAL KNOWLEDGE OF THE PARTICULAR  
HEALTH CARE ITEM OR SERVICE THAT IS THE SUBJECT OF THE AUDIT AND  
WITH THE PROGRAM RULES GOVERNING THE HEALTH CARE ITEM OR  
SERVICE, AT THE TIME THE ITEM OR SERVICE WAS PROVIDED.**

**(B) (1) IF THE MEDICAL NECESSITY OF THE CLAIM IS THE SUBJECT OF THE AUDIT, THE ENTITY CONDUCTING THE AUDIT SHALL INCLUDE AS PART OF THE AUDIT TEAM AN INDIVIDUAL LICENSED IN THE SAME HEALTH OCCUPATION AS THE PROVIDER.**

**(2) THE INDIVIDUAL IDENTIFIED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL HAVE SIGNIFICANT KNOWLEDGE OF THE AUDITED PROCEDURE, BUT IS NOT REQUIRED TO BE IN THE SAME SPECIALTY OR PRACTICE AREA AS THE AUDITED PROVIDER.**

**2-705.**

**(A) (1) NOT LESS THAN 15 CALENDAR DAYS PRIOR TO THE COMMENCEMENT OF AN AUDIT BY THE DEPARTMENT UNDER THIS SUBTITLE, THE INSPECTOR GENERAL SHALL PROVIDE TO THE PROVIDER WRITTEN NOTIFICATION OF THE AUDIT, INCLUDING:**

**(I) THE STATISTICALLY VALID SAMPLING METHODOLOGY TO BE USED;**

**(II) THE NAME, CONTACT INFORMATION, AND CREDENTIALS OF EACH INDIVIDUAL CONDUCTING THE AUDIT, INCLUDING THE INDIVIDUAL VALIDATING THE METHODOLOGY;**

**(III) THE AUDIT LOCATION, INCLUDING WHETHER THE AUDIT WILL BE CONDUCTED ON-SITE AT THE LOCATION OF THE HEALTH CARE PROVIDER OR THROUGH RECORD SUBMISSION; AND**

**(IV) THE MANNER IN WHICH INFORMATION REQUESTED MUST BE SUBMITTED.**

**(B) UPON COMPLETION OF THE AUDIT, EXCEPT IN CASES WHERE THE OFFICE OF THE INSPECTOR GENERAL REFERS THE AUDIT FINDINGS AND CONCLUSIONS TO THE OFFICE OF THE ATTORNEY GENERAL MEDICAID FRAUD CONTROL UNIT OR OTHER APPLICABLE LAW ENFORCEMENT AGENCY, THE OFFICE OF THE INSPECTOR GENERAL SHALL CONDUCT AN EXIT**

**CONFERENCE WITH THE HEALTH CARE PROVIDER WHO OR WHICH IS THE SUBJECT OF THE AUDIT.**

**(1) DURING THE EXIT CONFERENCE, THE OFFICE OF THE INSPECTOR GENERAL SHALL:**

**(I) PRESENT THE HEALTH CARE PROVIDER WITH THE AUDIT DRAFT WRITTEN FINDINGS AND CONCLUSIONS AND THE ESTIMATED AMOUNT OF RECOVERY DUE AS A RESULT OF OVERPAYMENT TO THE PROVIDER; AND**

**(II) PROVIDE THE HEALTH CARE PROVIDER WITH THE FOLLOWING WRITTEN INFORMATION:**

**1. A CLEAR DESCRIPTION OF THE UNIVERSE FROM WHICH THE SAMPLE WAS DRAWN;**

**2. THE SAMPLE SIZE AND THE METHOD USED TO SELECT THE SAMPLE;**

**3. THE FORMULAS AND CALCULATION PROCEDURES USED TO DETERMINE THE AMOUNT TO BE RECOVERED;**

**4. THE LIST OF CLAIMS THAT WAS REVIEWED;**

**5. A DESCRIPTION OF EACH CLAIM NOTED IN THE ERRORS THAT RESULTED IN AN OVERPAYMENT; AND**

**6. A SPECIFIC LIST OF THE REGULATIONS, STATUTES, AND TRANSMITTALS ON WHICH THE INSPECTOR GENERAL RELIED IN DETERMINING THAT THE CLAIM WAS IMPROPER.**

**(2) (I) A HEALTH CARE PROVIDER MAY CHALLENGE THE DRAFT FINDINGS AND CONCLUSIONS WITHIN 30 DAYS FROM THE DATE OF THE EXIT CONFERENCE, UNLESS, BECAUSE OF THE SIZE AND SCOPE OF THE AUDIT, A LONGER PERIOD HAS BEEN NEGOTIATED WITH THE DEPARTMENT THROUGH A MUTUAL GOOD FAITH PROCESS, AND ADDITIONAL INFORMATION**

**REGARDING THE CLAIMS IS SUBMITTED TO THE DEPARTMENT OR INSPECTOR GENERAL.**

**(II) THE ADDITIONAL INFORMATION SUBMITTED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH MAY INCLUDE EVIDENCE SHOWING THAT:**

**1. THE CLAIMS USED IN THE SAMPLE WERE EITHER PAID PROPERLY OR PAID PURSUANT TO SECTION 2-703 OF THIS SUBTITLE; OR**

**2. THE AUDIT DOES NOT MEET APPLICABLE REQUIREMENTS OR REACH VALID FINDINGS AND CONCLUSIONS.**

**(3) FAILURE TO CHALLENGE THE FINDINGS AND CONCLUSIONS CONTAINED IN THE PRELIMINARY REPORT DOES NOT PRECLUDE A HEALTH CARE PROVIDER FROM APPEALING THE FINAL REPORT AND RECOVERY LETTER UNDER SUBSECTION (D) OF THIS SECTION.**

**(C) (1) THE OFFICE OF THE INSPECTOR GENERAL SHALL REVIEW ANY ADDITIONAL DOCUMENTATION SUBMITTED BY THE HEALTH CARE PROVIDER UNDER SUBSECTION (B) OF THIS SECTION OR PRESENTED AT ANY TIME DURING THE AUDIT.**

**(2) AFTER REVIEW OF ANY ADDITIONAL DOCUMENTATION SUBMITTED BY THE HEALTH CARE PROVIDER, THE INSPECTOR GENERAL SHALL, WHEN APPROPRIATE, RECALCULATE THE ERROR RATE USED IN EXTRAPOLATION AND ISSUE ITS FINAL REPORT AND RECOVERY LETTER.**

**(3) THE FINAL REPORT AND RECOVERY LETTER SHALL STATE THAT THE HEALTH CARE PROVIDER HAS 30 DAYS FROM THE DATE OF THE RECOVERY LETTER TO APPEAL THE FINDINGS IN THE REPORT PURSUANT TO TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE, COMAR 10.01.03 AND 28.02.01, AND § 2-207 OF THIS ARTICLE.**

**(D) (1) ON APPEAL, THE HEALTH CARE PROVIDER MAY PRESENT EVIDENCE OF A SECOND AUDIT USING THE SAME SAMPLING METHODOLOGY BUT BASED ON A DIFFERENT SAMPLE OF CLAIMS IDENTIFIED AND PRODUCED BY THE INSPECTOR GENERAL.**

**(2) UPON REQUEST OF THE HEALTH CARE PROVIDER, THE INSPECTOR GENERAL SHALL PROVIDE A NEW SAMPLE OF CLAIMS TO THE PROVIDER WITHIN 30 DAYS FROM THE DATE OF RECEIPT OF THE REQUEST.**

**(3) THE PROVIDER SHALL HAVE 60 DAYS FROM RECEIPT OF THE NEW SAMPLE IN WHICH TO CONDUCT THE AUDIT AND TO PROVIDE THE RESULTS TO THE INSPECTOR GENERAL, UNLESS A LONGER PERIOD HAS BEEN NEGOTIATED WITH THE DEPARTMENT.**

**(4) THE INSPECTOR GENERAL MAY REVIEW THE PROVIDER'S AUDIT FOR COMPLIANCE WITH THE REQUIREMENTS OF THIS SUBTITLE.**

**(E) THE RECOVERY SHALL BE STAYED UNTIL COMPLETION OF THE ADMINISTRATIVE APPEAL PROCESS.**

**(F) NOTHING IN THIS SUBTITLE SHALL LIMIT A PROVIDER FROM CHALLENGING THE ACCURACY OF THE DEPARTMENT OR INSPECTOR GENERAL'S AUDIT, INCLUDING:**

**(1) THE STATISTICAL AND EXTRAPOLATION METHODOLOGY USED IN THE AUDIT;**

**(2) THE CREDENTIALS OF ANY INDIVIDUAL WHO PERFORMED OR REVIEWED THE AUDIT; OR**

**(3) ANY OTHER REASONABLE BASIS.**

**(G) (1) THE STATE MAY ADOPT THE FINDINGS OF THE FEDERAL GOVERNMENT, INCLUDING THE ERROR RATE, IF THE FEDERAL GOVERNMENT CONDUCTS AN AUDIT THAT:**

**(I) CONCLUDES THAT A PROVIDER RECEIVED AN OVERPAYMENT;**

**(II) USES AN ERROR RATE THAT IS SPECIFIC TO A SINGLE PROVIDER;**

**(III) DERIVES THE OVERPAYMENT FROM A STATISTICALLY VALID SAMPLE; AND**

**(IV) PROVIDES ALL SUPPORTING DOCUMENTATION OF THE AUDIT.**

**(2) IF THE DEPARTMENT ADOPTS THE FINDINGS OF THE FEDERAL GOVERNMENT, IT SHALL PROVIDE TO THE HEALTH CARE PROVIDER A COPY OF THE FEDERAL GOVERNMENT'S AUDIT REPORT AND SUPPORTING DOCUMENTATION WITH THE PRELIMINARY RECOVERY LETTER STATING THE AMOUNT DUE TO THE STATE AND THE PROVIDER'S APPEAL RIGHTS.**

**(3) (I) WITHIN 30 DAYS OF RECEIPT OF THE PRELIMINARY RECOVERY LETTER, THE HEALTH CARE PROVIDER MAY CHALLENGE THE DRAFT FINDINGS AND CONCLUSIONS, UNLESS, DUE TO THE SIZE AND SCOPE OF THE AUDIT, A LONGER PERIOD OF TIME HAS BEEN NEGOTIATED WITH THE DEPARTMENT THROUGH A MUTUAL, GOOD FAITH PROCESS, AND ADDITIONAL INFORMATION IS SUBMITTED TO THE INSPECTOR GENERAL.**

**(II) THE ADDITIONAL INFORMATION SUBMITTED UNDER ITEM (I) OF THIS PARAGRAPH MAY INCLUDE EVIDENCE SHOWING THAT:**

**1. THE CLAIMS USED IN THE SAMPLE WERE EITHER PAID PROPERLY OR PAID PURSUANT TO SECTION 2-703 OF THIS SUBTITLE; OR**

**2. THE AUDIT DID NOT MEET APPLICABLE REQUIREMENTS OR REACH VALID FINDINGS AND CONCLUSIONS.**

**(4) FAILURE TO CHALLENGE THE FINDINGS AND CONCLUSIONS CONTAINED IN THE PRELIMINARY RECOVERY LETTER DOES NOT PRECLUDE A HEALTH CARE PROVIDER FROM APPEALING THE FINAL REPORT AND RECOVERY LETTER UNDER SUBSECTION (D) OF THIS SECTION.**

**(H) (1) THE INSPECTOR GENERAL SHALL REVIEW ANY ADDITIONAL DOCUMENTATION SUBMITTED BY THE HEALTH CARE PROVIDER UNDER SUBSECTION (B) OF THIS SECTION OR PRESENTED AT ANY TIME DURING THE AUDIT.**

**(2) AFTER REVIEW OF ANY ADDITIONAL DOCUMENTATION SUBMITTED BY THE HEALTH CARE PROVIDER, THE INSPECTOR GENERAL**

**SHALL, WHEN APPROPRIATE, RECALCULATE THE ERROR RATE USED IN EXTRAPOLATION AND ISSUE ITS FINAL REPORT AND RECOVERY LETTER.**

**(3) THE FINAL REPORT AND RECOVERY LETTER SHALL STATE THAT THE HEALTH CARE PROVIDER HAS 30 DAYS FROM THE DATE OF THE RECOVERY LETTER TO APPEAL THE FINDINGS IN THE REPORT PURSUANT TO TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE, COMAR 10.01.03 AND 28.02.01, AND § 2-201 AND § 2-207 OF THIS ARTICLE.**

**(4) THE RECOVERY SHALL BE STAYED UNTIL COMPLETION OF THE ADMINISTRATIVE APPEAL PROCESS.**

**(I) THIS SUBTITLE DOES NOT APPLY TO AUDITS CONDUCTED IN RESPONSE TO FEDERAL AUDITS INITIATED BEFORE OCTOBER 1, 2016.**

**SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2016.**



Attachment B  
HB1101 (2015) Workgroup  
Comparison Chart

Original Legislation	Industry's Proposal	Department's Final Proposal
<b>Subpoena Authority</b>		
Inspector General or a <i>Designee</i> of the Inspector General.	Accepted Dept's. proposal proposed at workgroup meeting.	The Inspector General or a Designated <i>Assistant Inspector General</i> .
<b>Surety Bond</b>		
General authority to require MA provider or MA Applicant to provide surety bond. If required by MC, bond would equal amount required by MC, otherwise other factors determine amount.	Opposed Surety bonds.	No surety bond in the Program Integrity Bill.
<b>Civil Money Damages</b>		
May not exceed amount of claim.	Industry submitted a slightly more detailed proposal than Dept's. original legislation.	Adopted Industry's proposal with 4 changes/additions.
In lieu of retraction of the claim.		Agreement to call it civil money remedy.
Factors listed to assist in calculation of amount.		Remedy may not be less than the FFP of the claim.
Appeal process-- Administrative Procedure Act.		Remedy is within sole discretion of IG and limited by fed and state statutes governing overpayments.
		Deleted reference that funds recouped return to program.
<b>Extrapolation</b>		
Enabling language to permit Dept. to extrapolate error rate if required by fed'l statute, or high error rate, or if education has failed.	Limit extrapolation to when feds audit. Majority of proposal equals Dept's. Final.	Agreed to limit to when feds audit. Defined fed'l gov't.
Lookback 36 months.	1. Statistically valid sampling methodology requires 95% confidence level.	1. Requires 90% confidence level (level used by feds).
	2. Audits conducted by Dept. or IG.	2. Audits conducted by IG (changed at request of industry).
	3. Lookback limited to 36 months.	3. No limit on lookback, as will adopt fed'l audits' scope.
	4. Error rate shall not include clerical errors.	4. Error rate WILL include clerical errors per fed policy.
	5. Audit to be performed in accordance with generally accepted auditing standards and statement on accounting standards.	5. Performed in accordance with the methodology used by federal govt or GASS or SAS.

Attachment B  
HB1101 (2015) Workgroup  
Comparison Chart

Extrapolation (continued)	Industry's Proposal	Department's Final Proposal
	6. Appeal process permit new sample.	6. Adopted industry's language.
	7. If issue is clinical, entity conducting	7. If the medical necessity of the procedure claimed is
	shall include as part of audit team, an	the subject of the audit...shall include...an individual licensed
	individual licensed in same clinical	in the same health occupation and have significant
	discipline.	knowledge of the procedure; however does not need to be
		of same specialty or practice area.
	8. 2-705(A) At least 30 days notice of audit.	8. At least 15 days notice of audit.
	9. 2-705 (C ) 60 days to appeal from date	9. 30 days to appeal. (This is standard with DHMH-OIG
	of recovery letter.	audits.)
	10. 2-707 May not initiate further audits	10. No similar language. Too broad an exclusion for certain
	while audit is being conducted unless	providers.
	credible allegation.	
	11. Effective date- not apply to DOS prior	11. Subtitle may not apply to audits conducted in response to
	to 1/1/17.	federal audits initiated before 10/1/16.
	12. Silent on this topic.	12. Language to permit IG to adopt findings if fed'l audit is
		of a single provider, and thus error rate is particular to the
		provider.

## Attachment C

PETER A. HAMMEN  
46th Legislative District  
Baltimore City

Chair  
Health and Government  
Operations Committee



THE MARYLAND HOUSE OF DELEGATES  
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April 13, 2015

Van T. Mitchell  
Secretary  
Department of Health and Mental Hygiene  
201 W. Preston Street  
Baltimore, MD 21201

Dear Secretary Mitchell:

House Bill 1101 – Department of Health and Mental Hygiene – Health Program Integrity and Recovery Activities – sought to provide the Department, particularly the Inspector General, with additional tools in fighting fraud, waste, and abuse in State health care programs. The bill was a late introduction, and health care provider groups uniformly opposed it. Although the Public Health and Minority Health Disparities Subcommittee worked hard on amendments to narrow the scope of the bill, clarify terms, and provide for stakeholder input on regulations, it became clear that there was insufficient time remaining in the legislative session to overcome the provider opposition.

In the Subcommittee work sessions on the bill, provider representatives expressed willingness to work in collaboration with the Department to craft a bill for introduction at the 2016 session. I respectfully request that the Department convene a workgroup of provider representatives and other interested stakeholders to advise the Department on this matter. All interested groups should be invited to participate and express their views and ideas in an open and collaborative manner. I am convening a meeting today with the stakeholders to urge their participation in the workgroup.

While I do not wish to place any constraints on the 2016 legislation that should emerge after consultation with the workgroup, I would expect that, at minimum, the legislation would:

- Provide the Department with the same tools used by the U.S. Department of Health and Human Services Office of Inspector General to determine and recover the amount of any overpayment by the Department to a provider as reimbursement for a health care service or a health care item provided to a participant; and
- Afford the providers full documentation of the basis for any finding of an overpayment and an opportunity to contest any finding of an overpayment through the Administrative Procedure Act.

I would like to receive a report by December 1, 2015, describing the deliberations and any findings of the workgroup, as well as the Department's recommendations for 2016 legislation. I fully expect to make this legislation a priority for the 2016 session. Committee analyst Linda Stahr will be monitoring the workgroup on behalf of the Health and Government Operations Committee.

Sincerely,



Peter A. Hammen

Cc: HB 1101 stakeholders